



# LOS ANGELES COUNTY COMMISSION ON HIV

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## PRIORITIES & PLANNING (P&P) COMMITTEE MEETING MINUTES

June 10, 2013

Approved  
3/17/2015

P&P MEMBERS PRESENT	P&P MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Carla Bailey, Commission Co-Chair	Whitney Engeran-Cordova	Miguel Fernandez	Jane Nachazel
Al Ballesteros, Co-Chair	Douglas Frye	Aaron Fox	Craig Vincent-Jones
Bradley Land, Co-Chair	Anna Long	Scott Singer	
Christopher Brown	Tonya Washington-Hendricks	Jason Wise	
David Kelly			DHSP STAFF
Abad Lopez			Juhua Wu
LaShonda Spencer			
Carlos Vega-Matos			

### CONTENTS OF COMMITTEE PACKET

- 1) **Agenda:** Priorities & Planning (P&P) Committee Meeting Agenda, 6/10/2013
- 2) **Spreadsheet:** Grant Year 22 Ryan White Part A, Single Allocation Model (SAM) Care and MAI Expenditures by Service Categories as of February 28, 2013, 5/21/2013
- 3) **Summary Key:** Ryan White Parts A and B and MAI Expenditures by Service Categories, 3/18/2013
- 4) **Table:** County of Los Angeles, Department of Public Health, Division of HIV and STD Programs, Non-Medical Case Management Extension, Client Profile, May 2013
- 5) **PowerPoint:** Other Streams of Funding for HIV/AIDS Services, 5/28/2013
- 6) **Table:** FY 2014 Proposed Service Allocations, 5/28/2013
- 7) **Policy/Procedure:** #05.4001: Service Category Definitions and Related Rules and Requirements, revised 3/7/2013
- 8) **Memorandum:** FY 2014 Priority Ranking Recommendations, 5/2/2013
- 9) **Table:** FY 2014 Proposed Service Allocations, Part A/Part B and MAI, 6/10/2013

1. **CALL TO ORDER:** Mr. Land called the meeting to order at 12:35 pm. Attendees identified their conflicts of interest.

2. **APPROVAL OF AGENDA:**

**MOTION #1:** Approve the Agenda Order (**Passed by Consensus**).

3. **APPROVAL OF MEETING MINUTES:** Minutes will be approved by the Commission as current committees are ending. Committees for the new, unified Commission will begin meeting in September 2013.

**MOTION #2:** Approve the Priorities & Planning (P&P) Committee Meeting Minutes (**Withdrawn**).

4. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP:** There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP:** There were no comments.

6. **CO-CHAIRS' REPORT:** There was no report.

7. **FY 2014 PRIORITY- AND ALLOCATION-SETTING (P-AND-A):**

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- A. **Review of Funding Priorities:** P&P reviewed their funding priorities at the 5/28/2013 meeting. A table on preliminary recommendations for whether to increase, decrease or maintain FY 2013 funding levels was in the packet.
- B. **Contingency Funding Priorities:** Mr. Vincent-Jones considered alternate funding scenarios and found insufficient data to develop a formal structure like that used previously. P&P may identify key priorities, ranges and any differences that may pertain to deeper than anticipated funding reductions. The new, unified Commission will address new data as it is received.
- C. **Key and Priority Populations:** There was no additional discussion.
- D. **Resource Allocation-Setting:**
  - Mr. Vega-Matos reported DHSP reviewed recommendations from the last meeting and prepared its recommendations based on what is known so far about sequestration, Low-Income Health Program (LIHP) migration as of 5/1/2013 and current contracts. DHSP provided a table of recommendations for Parts A/B and Minority AIDS Initiative (MAI) funds.
  - Ms. Wu noted DHSP has not received its FY 2013 award, but expects a 6-7% reduction. It expects a 10% reduction from FY 2012 to FY 2014 based on sequestration with estimates of \$35.7 million for Parts A/B and \$2.5 million for MAI.
  - DHSP appreciates P&P would like to use savings from migration to other systems such as LIHP to restore or increase services, but the same percentage equals fewer dollars when funding is cut so the DHSP focus is to maintain services.
  - The 10% sequestration estimate is from the 5% sequestration in FY 2013 with an additional 5% in FY 2014. Mr. Vega-Matos said DHSP has some flexibility to absorb reductions and should be able to do so in FY 2013. If reductions go beyond the DHSP ability to absorb them, DHSP has the ability to amend contracts.
  - Ms. Wu added 1,000-1,200 patients are expected to migrate with implementation of the Affordable Care Act (ACA). Mr. Vincent-Jones asked about the previous estimate of 5,000 patients. Mr. Vega-Matos replied 5,000 of the 15,000 receiving Ryan White services were estimated to migrate to LIHP. Ryan White requires reporting anyone who touches the system, but many of these only receive medical services while Medi-Cal/Medicare applications are pending.
  - Ambulatory Outpatient Medical (AOM) Fee-For-Service (FFS) more accurately identifies such patients many of whom will continue to receive other services. The estimate of those migrating to ACA is based on income of those interacting with Casewatch. Data will improve as Casewatch is refined and providers improve data entry required by AOM FFS.
  - Mr. Land noted Ryan White is increasingly oriented towards filling gaps, e.g., while Medi-Cal/Medicare is pending, out of pocket expenses for other systems and service gaps. Mr. Fox added there is no Ryan White guidance on migrating people to health exchanges smoothly or how to fill non-medical service gaps after migration.
  - DHSP Part A/B recommended revisions from FY 2013 to FY 2014 were:
    - ↳ *Medical Outpatient/Specialty (MO/S)*, ↓ 42.1-36.0%: YR 3 AOM contract levels are \$13.9 million with Medical Specialty at \$1.5 million, estimated Therapeutic Monitoring Program (TMP) at \$1 million and estimated ACA migration savings resulting in anticipated underspending for total estimated expenditures of \$13 million (36.0%);
    - ↳ *Medication Assistance and Access*, ↓ 4.5-2.0% all for Local Pharmacy Program/Drug reimbursement: California is funding ADAP enrollment separately while Pharmacy is contracted at \$1 million with anticipated underspending for total estimated expenditures of \$714,000 (2.0%);
    - ↳ *Oral Health Care*, ↑ 11.3-20.0%: Primary funding including for Phase III of \$7.14 million augmented by MAI funds;
    - ↳ *Medical Care Coordination (MCC)*, ↑ 14.1-16.0%: \$8.9 million (24.9%) contract level based on AOM savings from patient migration not including potentially significant funding reduction with an assumed Part A/B funding level of \$5.7 million and support from Net County Cost (NCC);
    - ↳ *Benefits Support*, ↑ 2.0-2.5% increasing Health Insurance Premiums/Cost-Sharing from 0.0-0.5%: Support for copayments and deductibles;
    - ↳ *Linkage to Care Services (LTC)*, ↓ 1.0-0.5%: Primarily supported by MAI;
    - ↳ *Transitional Case Management (TCM)*, ↓ 1.2-0.2%: Primarily supported by MAI;
    - ↳ *Optometry Services*, ↓ 1.0-0.0%: No mechanism to contract for this service within the timeframe.
  - DHSP MAI recommended revisions from FY 2013 to FY 2014 were:
    - ↳ *Oral Health Care*, ↑ 30.0-40.0%: \$1 million to help support Phase III expansion;
    - ↳ *Medical Care Coordination (MCC)*, ↓ 45.0-0.0%: MCC supported by Part A/B;
    - ↳ *Linkage to Care Services (LTC)*, ↑ 25.0 (early intervention) -40.0%: Primary support at \$1 million;
    - ↳ *Transitional Case Management (TCM)*, ↑ 0.0 (new) - 20.0%: Primary support at \$500,000 of \$571,400.
  - Mr. Vincent-Jones noted at the 5/28/2013 meeting P&P identified preliminary increases, decreases or maintenance for various categories and asked why DHSP recommendations differed.

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- Mr. Vega-Matos replied preliminary determinations assumed same or increased funds due to migration. DHSP expects a 10% cut due to sequestration so focused on preserving existing services and ensuring new MCC services and the planned Oral Health Phase III expansion. He noted the discussion on increasing Medical Nutrition Therapy, defunded in 2009 due to funding cuts, but said AOM Pharmacy contracts allow outpatient medical providers with a pharmacy location to provide supplements. The DHSP Care Services team will review utilization for those providers.
- DHSP internal discussions raised the most concerns about housing case management. It was decided better knowledge about HOPWA resources and whether they are effectively deployed was needed before any potential increase.
- Mr. Singer asked about NCC funds. Mr. Vega-Matos replied they support several services including Residential Care and Housing and a significant portion of MCC. They also help fill gaps in other funding.
- Mr. Vega-Matos reported DHSP recommendations for AOM were for three years. YRs 1 and 2 factored in estimated LIHP migration while YR 3 assumed completed LIHP migration. ACA migration was not estimated due to inconclusive data, but internal estimates were used for contracting. Contracts include medical visits, labs, pharmacy and imaging.
- The current YR 2 rate per medical visit is \$330.12. The rate will reset to \$284 after year end on 7/1/2013. Rates will then fluctuate based on performance with the difference funded through NCC.
- Continuity of care for those migrating out of Ryan White remains a concern. It will likely be more difficult to achieve with migration to Covered California under ACA that it has been with LIHP due to stakeholder coordination issues.
- DHSP put Medical Specialty out to bid with AOM at \$1.5 million for community-based and \$1 million for Department of Health Services (DHS) services. DHS decided not to use the \$1 million this year and has not communicated about any plans going forward due to other funding streams. Consequently, DHSP recommendations only reflect the \$1.5 million.
- Mr. Vincent-Jones asked about Therapeutic Monitoring Program trends since funding has declined over the years from \$4 to \$1 million yet genotyping seems more common. Mr. Vega-Matos said decreases are mainly due to lowered costs as genotyping/phenotyping becomes standard care and using the Department of Public Health Laboratory including its option for less costly virtual phenotyping. DHSP will continue to fund genotyping for those migrating from the system.
- Mr. Vincent-Jones asked why DHSP would retain some MAI funds for Oral Health despite P&P's 5/28/2013 decision to allocate 75% to LTC and 25% to TCM. Mr. Vega-Matos said Parts A/B are insufficient for Oral Health including Phase III without sharp cuts to other services. Also, LTC is still ramping up so is unlikely to be able to spend the entire allocation.
- Mr. Vega-Matos said DHSP is focusing on expanding contracts with approximately 16 existing providers for Phase III. Three providers from Phase II, two new to Oral Health, have not yet initiated service and one Phase I provider, also new, just started in January 2013. It is hoped using existing providers for Phase III will allow quicker ramp up. Potential providers have received letters requiring them to respond within four weeks detailing their ability to increase capacity.
- There are approximately 18,000 unduplicated Ryan White clients of whom approximately 15,000 have historically received medical outpatient care requiring at least one medical visit. Even with migration, most patients will still require Oral Health services. While California may reinstate Denti-Cal, those services are limited. Most Oral Health providers also previously provided Denti-Cal. Current Oral Health capacity is 10,000 patients. It is a cost reimbursement service. Recommendations were based on contract levels with a small amount of underspending.
- DHSP recommended an increase in MCC funding versus P&P's previous flat funding recommendation. Mr. Vega-Matos noted there are now contracts for \$8.9 million or 24.9% of Part A/B funding. DHSP recommended an increase from 14.1% to 16%, but the service category will still require supplementary NCC funding.
- DHSP concurred with P&P to increase Benefits Support and recommended increasing the Health Insurance Premiums/Cost-Sharing sub-category from 0.0% to 0.5% for an overall allocation of 2.5%. Mr. Vega-Matos said funds will support co-pays and deductibles through providers with Ryan White medical homes whether or not patients accessing the service use the medical homes. DHSP does not currently have a procedure for other providers.
- ADAP will cover premiums. Ryan White is prohibited from covering Medi-Cal/Medicare share-of-cost.
- Mr. Singer was concerned providers with Ryan White medical homes will have a competitive advantage over others. Mr. Vega-Matos said that was possible, but this was meant to be an initial, limited attempt to remove barriers to care mainly for those moving to Covered California plans. Going beyond Ryan White providers is much more complex.
- Mr. Ballesteros felt provider staff would require training to deploy the service. Mr. Vega-Matos agreed, but noted it is just one of many training areas that all benefits counselors and financial screeners will need as ACA rolls out.
- P&P had recommended flat Part A/B funding of 1% for LTC while DHSP recommended reducing it to 0.5%. Both identified MAI as primary funding. DHSP felt 0.5% sufficient to address non-MAI population clients.

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- Both P&P and DHSP proposed primary MAI funding for TCM and reduced Part A/B from 1.2% with DHSP proposing 0.2%. Mr. Vincent-Jones questioned the efficacy of so small an allocation. Mr. Vega-Matos replied it is to address MAI TCM programs that occasionally serve a non-MAI client. Providers can only be paid for such clients via Part A/B.
  - DHSP recommended continued 0.0% funding for Residential Care and Housing and Housing Supportive although P&P had sought to fund both. There is a concern about federal and state funding cuts, but there are also HOPWA coordination issues. The body agreed to address housing once the new Commission's HOPWA seat is filled.
  - While P&P had suggested increasing Retention in Care, it accepted flat funding to preserve resources.
  - P&P had proposed increasing Substance Abuse versus the DHSP flat funding proposal. Mr. Vincent-Jones said the Commission, especially in the last year, highlighted substance abuse as a key epidemic driver and discussed new biomedical approaches so he felt flat funding contradictory. Mr. Vega-Matos noted other funding sources such as C-SAT. Meanwhile, DHSP is assessing and revamping services so he preferred flat funding until services could be revised.
  - DHSP recommended continued 0.0% funding for Medical Nutrition Therapy although P&P had sought to fund it. Mr. Vega-Matos had agreed at the 5/28/2013 meeting to review utilization of supplements under AOM, but Mr. Vincent-Jones felt the main issue was access to dieticians, including capacity to address the nutritional element of HIV. Mr. Vega-Matos said some AOM providers include dieticians in their budgets, but he did not know to what extent.
  - DHSP recommended reducing the FY 2013 1.0% allocation for an Optometry pilot project to 0.0% while P&P had recommended maintaining it. Mr. Vincent-Jones acknowledged DHSP was having difficulty in developing the new service, but felt defunding the effort was self-defeating. The body agreed to maintain the 1.0% pilot project funding for Optometry. While affirming support for Phase III Oral Health, the 1.0% was taken from that service category.
  - DHSP recommended flat funding of 6.8% for Home-Based Care although P&P had sought to increase it to address an aging population. The body agreed to flat funding at this time in lieu of limited resources.
  - DHSP and P&P agreed on flat funding for Long-Term and Palliative Care, 0.5%; Rehabilitation and Respite Care, 0.0%.
  - Mr. Vega-Matos summarized priority services identified by P&P as AOM, Oral Health, MCC, Mental Health, LTC and Benefits Support. DHSP also committed to: review access to Medical Nutrition Therapy as a whole, including dieticians and supplements; examine deployment of co-pays and deductibles across systems; continue working on development of substance abuse services; attempt to develop Optometry; and discuss housing coordination issues with HOPWA.
- ⌚ DHSP will develop a report on those receiving transitional medical care while Medi-Cal/Medicare is pending.
- ⌚ Mr. Vega-Matos will follow-up again with DHS on its plans, if any, for Medical Specialty services through DHSP.
- ⌚ Mr. Vega-Matos will follow-up on genotyping data with Dr. Sonali Kulkarni and David Pieribone.
- ⌚ Identify TCM allocation of 0.2% as a placeholder to serve non-MAI clients and establish a policy to ensure that a service primarily funded by MAI will also have a sufficient Part A/B allocation to address the needs of non-MAI populations.
- ⌚ Expand 5/28/2013 Directive to DHSP to investigate and report back to PP&A on roadblocks to supplement access via AOM to include capacity for and access to dieticians.
- ⌚ Recommendation to DHSP to assess harm reduction services in residential facilities.
- ⌚ Defer discussion on any additional directives to the September 2013 PP&A meeting.
- ⌚ The base funding level scenario for FY 2014 Ryan White Part A/B and MAI allocations is a projected 10% reduction from FY 2012 funding levels. PP&A will review other possible scenarios in September 2013 when more data is available.

**MOTION #3:** (*Land/Bailey*): Accept the Division of HIV and STD Programs allocation recommendations for FY 2014 Ryan White Parts A/B and Minority AIDS Initiative funding except that Oral Health Care will be allocated 19% of Ryan White Part A/B grant funds and Optometry Services will be allocated 1% (**Passed: Ayes**, Bailey, Ballesteros, Brown, Kelly, Land, Spencer, Vega-Matos; **Opposed**, None; **Abstention**, None).

**8. FY 2013 P&P COMMITTEE WORK PLANNING:** There was no additional discussion.

**9. NEXT STEPS:** There was no additional discussion.

**10. ANNOUNCEMENTS:** There were no announcements.

**11. ADJOURNMENT:** The meeting adjourned at 3:55 pm.